

ORIGINAL ARTICLE

## Women's strategies for handling chronic muscle pain: A qualitative study

SISSEL STEIHAUG

SINTEF Helse, Oslo, Norway

### Abstract

**Objective.** Medicine lacks good models for understanding and treating chronic muscle pain. The aim of this study was to explore whether participation in a treatment group for women with chronic muscle pain can help the participants to develop strategies to handle their chronic muscle pain. **Methods.** The study was carried out as a qualitative research project. Eight women completed a treatment programme consisting of movement training and group discussions. The qualitative data consisted of transcriptions from audio-taped individual interviews. The data material was analysed by systematic text condensation inspired by Giorgi. **Results.** All the women describe participation in the treatment group as useful. Their experiences could be categorized as follows: To know oneself, to negotiate with oneself and others, to be able to choose, and to be able to act. **Conclusion.** The participants developed strategies for handling their chronic muscle pain. Both the women's new understanding of their chronic muscle pain and increased confidence in themselves were important. These phenomena can help women in their encounters with their surroundings, for example when consulting doctors. The doctor's awareness of the women's resources and their own mastering strategies may contribute to a new understanding of the disposing, triggering, and maintaining factors, and of the curative and health-promoting forces at work in those with chronic muscle pain.

**Key Words:** *Family practice, mind–body relations, myofascial pain syndromes, qualitative research, women's groups*

In our society, the medical disease model dominates, and the health services preside over the right to decide what is disease and what is not. The doctors are in command of expert language – separate from experiencing and nearness – which is accepted as the “truth” in the field. One such truth is that bodily pain should leave traces in the body. This creates problems for patients who consult the doctor with chronic muscle pain, because a typical aspect of these conditions is that doctors do not in fact find anything wrong when they examine the body.

Many patients feel misunderstood and rejected [1–3], and doctors consider that such patients are difficult to help [4–7]. Both the doctors and the patients are frustrated by not being heard and believed: the patient because the doctors do not believe and acknowledge their symptoms, and the doctors because the patients do not believe and acknowledge their explanations of causes [3].

Participation in a treatment group with movement training and discussion helped women develop strategies for handling their chronic muscle pain.

- These strategies include knowing oneself, negotiating with oneself and others, being able to choose, and being able to act.
- Women's new understanding of their chronic muscle pain and increased confidence in themselves were important.
- These phenomena can help women in their encounters with their surroundings, for example when consulting doctors.

Medicine lacks good models for understanding and treating chronic muscle pain. A phenomenological perspective may be helpful [8]. Our natural acceptance of the human body develops by experiencing the world with and through our body, and by

reflecting on our encounters with the world [9,10]. Experiences leave traces in the body as body habits and reaction patterns – posture, mimicry, and movements. We acquire mental and bodily attitudes to ourselves, to the world, and to other people. Security or insecurity experienced during childhood can result in different body habits and reaction patterns. A continuous “being on guard” attitude may be expressed by the body as holding the breath, tensing musculature, and a restricted movement pattern. Lilleaas has developed the concept “*bodily preparedness*” to describe the bodily experience of many women with chronic muscular pain [11]. Our movement patterns will influence the type of physical strains we experience and the kind of functional problems we may develop. Body habits are usually unconscious, and they have to be discovered before they can be changed.

Using this as a starting point, a physiotherapist and a doctor (the author) developed a group-based treatment regimen for women with chronic muscle pain, in the primary health service. Twelve treatment groups with a total of 143 participants have been completed. The training programme is based mainly on the type of physiotherapy known as basal body awareness therapy [12], where awareness of the connection between breath and muscle tension is a central element. The target is to alter stressful body habits and obtain better balance, reduced muscle tension, and more freedom when breathing. The group discussions are an integrated part of the treatment programme and the objective is to encourage collaboration characterized by acknowledgement [13]. The physiotherapist leads the training and the doctor leads the discussion group.

The aim of this study was to explore whether participation in a treatment group for women with chronic muscle pain can help the participants to develop strategies for handling their chronic muscle pain.

#### *Group treatment*

Eleven women who had long-lasting or repeated episodes of sick leave for chronic muscle pain were offered participation in a treatment group for women with chronic muscle pain, arranged in a district in Oslo in 2004. The women were referred by their doctors, their physiotherapists, or they made contact themselves. The participants came for a consultation with the doctor (the group leader) and a consultation/examination with the physiotherapist before starting treatment. The women were unknown to the doctor prior to the group treatment.

Eight women completed the treatment programme. They were aged 29 to 56 years, average

42 years. Two participants had a college education, three had one year of further education, and three only had primary and lower secondary school education. Three women were working full time, four were on partial sick leave, and one was being rehabilitated.

#### *Treatment programme*

The treatment included movement training in a group for one hour and group discussion for one hour per week for eight months. Subjects such as muscle and pain physiology, communication, and how “life leaves its marks on the body” were emphasized in the instruction; in the group discussions these subjects were linked to personal experiences.

### **Material and methods**

The qualitative data consisted of transcriptions from audio-taped individual interviews. All the participants were interviewed individually by the author immediately after completing treatment. In semi-structured interviews the women were asked about the possible benefits of participating in the treatment group and, if any, how these benefits could help them in their everyday lives. The interviews lasted for about one hour and the tape recordings were written out almost verbatim.

The data material was analysed by systematic text condensation inspired by Giorgi [14,15]. The analysis process was carried out in four steps. First, all the interviews were read several times to get a general sense of the entire data material. Second, the interviews were reread once more with the aim of discriminating “meaning units”. Attention was focused on the participants’ own experienced benefit. Third, four code groups were obtained, and lastly a description of the contents of each code group were constructed. The four final categories were obtained by using the headlines of the code groups: (a) to know oneself, (b) to negotiate with oneself and others, (c) to be able to choose, (d) to be able to act.

### **Results**

#### *To know oneself*

All the participants said that they had learnt something about themselves and their own way of life and reaction patterns while they were in the treatment group. They had discovered things about their own bodies during the exercises, and they had talked about their experiences in the discussion group. Several stressed that directing attention inwards and recognizing feelings were new experiences for

them, and some said that this was sometimes uncomfortable. One of the older women said:

*When I was lying resting and coming to terms with myself, my body felt uncomfortable and I noticed sadness. . . . I realized that there is something lying stored there, and that is what life is. I am not used to looking inwards. Although many things are stored there, they do not necessarily all have to come out.*

The women considered that they had altered both their perception of pain and their relation to it. Many had understood more clearly how pain is connected with earlier experiences, present life circumstances, and individual habits and way of life, and that it is less often something that hits at random from the outside. For example, one woman had discovered that her attitudes were coloured by being brought up in a strongly Christian home in Southern Norway, and she described how this had resulted in a certain body tenseness – making certain that she was always acting correctly. She realized that somatic and psychological factors are related to each other.

One woman with neck pain said:

*Getting to know myself was a completely new concept. Now I know that if something happens, it will affect my body. A couple of weeks ago I found a family party stressful, and I could feel how it affected my neck. Although I have a prolapse, these events affect me – everything is interconnected.*

#### *To negotiate with oneself and others*

A recurrent theme of the interviews was that the participants had started debating things with themselves, for example whether they should do things that they did not want to do, have a bad conscience, or become stressed or irritated. They emphasized that realizing that problems existed could be enough, it is not always necessary to say anything or to act.

*I was left with a bad feeling when I had said that I couldn't have the bible group – and at the same time I was proud of myself for being able to say "no". Previously I had had the group because it was expected of me. I must just tolerate the bad feeling. It is up to me to work on it.*

The women said that they now knew better what they wanted and did not want, and most of them thought they were better at expressing themselves. Previously they had tended to expect that others would say what was needed but they had discovered that as adults one must express one's own opinion.

They thought that they were better at negotiating for help instead of expecting others to notice their needs. They mentioned many examples of negotiations with their family, friends, and colleagues. They were also better at tackling doctors and physiotherapists.

*I can say "no" to more things at work. But it feels awful, and I get rather a bad conscience. . . . But I am really very pleased with myself when I have managed to say "no". And it has not led to problems with the people I have said "no" to. People do not react as negatively as I thought.*

*I feel a little stronger in my relationship with the doctor now. I feel that I know more than she does. In the future I will tell her when I don't agree with her.*

#### *To be able to choose*

All the participants emphasized how important it is to be allowed to choose. Many had felt that they had little influence on conditions at work or at home. Gradually more of them were able to see that choices are available. The women said that they had learnt to find out what they wanted, and that it is in fact often possible to choose what one needs rather than what others expect. They mentioned many examples of things that they would have done previously without really wanting to, and to which they could now say "no", for example babysitting, inviting guests, or doing an extra shift at work. To recognize whether one can manage or benefit from something was mentioned as a new experience, and several women talked about "feeling it in my body". One woman mentioned becoming aware of the choice between saying "no" and developing pain as a result of not saying anything:

*If, for example I have been treated unfairly, I feel it first in my stomach and chest, feel that I am becoming very unhappy. Then it creeps up into my neck unless things get sorted out! It all hangs together, that's how it is. I think that if I manage to say when something is wrong, I can avoid having neck pain.*

#### *To be able to act*

The possibility of taking actions and starting something when it was needed was important for everyone. They talked about physical activity such as going for walks, cycling, swimming, etc. and about concrete exercises from the training programme, both in order to become calm and relaxed, and also for the direct relief of pain.

*I notice a great difference, because I am aware of what I am doing. I am very conscious of having open knees and letting my weight fall down into my legs. I use this strategy very often; it helps the pain in my neck and shoulders.*

The women on the whole felt that in general they had extended their repertoire of actions. Several said that when they understood that changing themselves was up to them, they became more able to act and took the initiative more often. To act could mean to do something or to consciously refrain from doing something, such as not washing floors but sitting down with a good book instead. One woman said:

*I have made more room for myself – now I go for walks with a friend every Wednesday. That's my day.*

Others made room for themselves in other ways:

*I have discovered that if I speak my mind a little more at work – both praise and criticism – my situation at work improves. It is partly up to me as well.*

## Discussion

### Method

The author's dual position as group leader and researcher is a challenge, and reflexivity is required [15]. An attempt was made to clarify preconceptions, account for the research process, and demonstrate how the analysis was performed.

The interview is a good way to obtain knowledge concerning personal experiences and the significance attached to these by the individual. The group leader herself led the interviews, and should therefore be extra-aware of her own position and open to new perspectives. The advantage here is that the interviewer has the necessary field knowledge. Data were created in cooperation between interviewee and interviewer, and another interviewer could have achieved other results. Dialogues are complex and multilayered, and open to producing different but valid interpretations. The participants used personal language to describe discoveries, bodily experiences, changes, and action strategies that differed from the language we use as group leaders, and I was surprised by many of the accounts. It is thus likely that the interpretation presented here is one of the more likely and that the participants were describing their own experiences and not repeating parts of our instruction.

*Altered self-understanding makes it possible to make changes*

It appeared from the results that the women had developed strategies for handling their chronic muscle pain. Many had changed their understanding of pain and did not perceive the pain as either biological or mental but realized that bodily and mental aspects of the pain cannot be separated. They were able to see connections between the pain experienced and who they were and how they lived. The pain became less diffuse and more logical.

The results indicate that the women had strengthened their belief in their own experiences and body habits, thus obtaining a clearer picture of and more confidence in themselves. They may also have developed more language to express their own experiences and how they interpret them. The women discovered that they could choose to change themselves. In the interviews they emphasized how important it was that they could improve their lives on their own initiative by slight changes, and that this could lead to greater changes in the long term. The feeling of being able to choose is important, although the women in this group all had jobs where it was difficult to affect their own conditions at work.

### Encounters with others

Although it is generally accepted today that disease is largely a cultural and history-related phenomenon, medicine still lacks a systematic humanitarian perspective on health and disease. Understanding the essence of disease is to some extent a question of interpretation [16]. Diagnostic assessment is concerned with interpretation and brings up a number of questions related to the ability to create meaning. In the consultation, the expert language of the doctor is confronted with the patient's own account of her experiences. When one's own experiences butt up against expert language, it is easy to feel powerless. We create an identity for ourselves and a way of existing in the world that is closely connected to language. When a language presentation of individual experiences is not understood or acknowledged as legitimate, it is easy to feel rejected as a person as well.

Increased confidence in themselves may strengthen the women in their encounters with their surroundings. For example, the encounter with the doctor may change character.

The women said in the interviews that they were able to explain their position more clearly, and thought that consultations with the doctor would be easier after this. Having more confidence in their own experiences, the women can express their symptoms using a language that may challenge the

doctors' own expert language. The doctors have the power of interpretation, defining the limits of what it is possible to say or not to say in a consultation, what can be valued and understood, and what cannot [17]. The women may strengthen their position in relation to the doctor as a result of increased awareness of and strengthened belief in their own individual and concrete experiences of life, increased confidence in their own language, and more knowledge of chronic muscle pain.

Even when movement training and group discussions are not available, the participants' experiences may be useful for doctors in their encounters with women patients with chronic muscle pain. It is important to acknowledge the patient and the patient's symptoms [18]. This implies having a basic respect for her experience-based perspective but not necessarily agreeing with her explanation of causes or recommendation for treatment. The knowledge possessed by both parties must be validated, and different models for understanding should be allowed to exist concurrently. The patient will then be able to present herself more precisely to the doctor, and the doctor will be able to present herself more precisely to the patient. The objective is change – that the women are able to develop strategies for handling their chronic muscle pain. When treatment is discussed in collaboration between doctor and patient, the patient is given space to act and change alternatives are developed. Awareness of the women's resources and their own coping strategies may contribute to a new understanding of the disposing, triggering, and maintaining factors, and of the curative and health-promoting forces at work in those with chronic muscle pain.

### Acknowledgements

Funding for this study was provided by the Norwegian Foundation for Health and Rehabilitation through the Norwegian Women's Public Health Association.

The study has been approved by the Regional Committee for Medical Research Ethics.

### References

- [1] Söderberg S, Lundman B, Norberg A. Struggling for dignity: The meaning of women's experiences of living with fibromyalgia. *Qual Health Res* 1999;9:575–87.
- [2] Peters S, Stanley I, Rose M, Salmon P. Patients with medically unexplained symptoms: Sources of patients' authority and implications for demands on medical care. *Soc Sci Med* 1998;46:559–65.
- [3] Kenny DT. Constructions of chronic pain in doctor–patient relationships: bridging the communication chasm. *Patient Educ Counselling* 2004;52:297–305.
- [4] Sharpe M, Mayou R, Seagroatt V, Surawy C, Warwick H, Bulstrode C, et al. Why do doctors find some patients difficult to help? *Q J Med* 1994;87:187–93.
- [5] Reid S, Whooley D, Crayford T, Hotopf M. Medically unexplained symptoms – GPs' attitudes towards their cause and management. *Fam Pract* 2001;18:519–23.
- [6] Wileman L, May C, Chew-Graham CA. Medically unexplained symptoms and the problem of power in the primary care consultation: A qualitative study. *Fam Pract* 2002;19:178–82.
- [7] Lundh C, Segesten K, Björkelund C. To be a helpless helpoholic – GPs' experiences of women patients with non-specific muscular pain. *Scand J Prim Health Care* 2004;22:244–7.
- [8] Steihaug S. Can chronic muscular pain be understood? *Scand J Public Health* 2005;33:36–40.
- [9] Engelsrud G. Kroppen som subjekt. En redegjørelse med utgangspunkt i Merleau-Ponty [The body as subject. An explanation based on Merleau-Ponty]. *Samtiden* 1992;2:56–61.
- [10] Vetlesen AJ, Stänicke E, Vetlesen AJ, Stänicke E. Fra hermeneutikk til psykoanalyse. Muligheter og grenser i filosofiens møte med psykoanalysen [From hermeneutics to psychoanalysis. Possibilities and limits in philosophy's encounter with psychoanalysis]. Oslo: ad Notam Gyldendal; 1999.
- [11] Lilleaas U-B. Kroniske muskelsmerter som endringspotensial [Chronic muscle pain as a potential for change]. I. Hvordan går det med dem? Utviklingsforløp hos kvinner med kroniske muskelsmerter [In: What happens to them. Processes in women with chronic muscle pain]. Work notes 4/96. Oslo: Centre for Women's Studies and Gender Research, University of Oslo; 1996.
- [12] Roxendal G. Body awareness therapy and the body awareness scale, treatment and evaluation in psychiatric physiotherapy. Thesis. Gothenburg: University of Gothenburg, 1985.
- [13] Steihaug S, Ahlsen B, Malterud K. From exercise and education to movement and interaction: Treatment groups in primary care for women with chronic muscular pain. *Scand J Prim Health Care* 2001;19:249–54.
- [14] Giorgi A. Sketch of a psychological phenomenological method. In: Giorgi A, editor. *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press; 1985. p. 1–22.
- [15] Malterud K. Qualitative research: Standards, challenges, and guidelines. *Lancet* 2001;358:483–8.
- [16] Stene-Johansen K. "Infectio". Om litteratur og sykdom. I Meyer S (red) *Avmakt. Skjebne, frigjøring eller maktbase?* ["Infectio". Literature and disease. In: Meyer S, editor. *Powerlessness: Destiny, liberation or power base?*]. Oslo: Gyldendal Norsk Forlag AS; 2000.
- [17] Meyer S. Blant de avmektige. I Meyer S (red) *Avmakt. Skjebne, frigjøring eller maktbase?* [Among the powerless. In: Meyer S, editor. *Powerlessness. Destiny, liberation or power base?*]. Oslo: Gyldendal Norsk Forlag AS; 2000.
- [18] Steihaug S, Ahlsen B, Malterud K. "I am allowed to be myself": Women with chronic muscular pain being recognized. *Scand J Public Health* 2002;30:281–7.